Chapter One

Overview of the Proposal

The primary objective of the Administration's proposal for health care reform, the Health Security Act, is to ensure that everyone has health insurance for a broad range of services. The proposal would establish a universal entitlement to a standard package of benefits to accomplish this goal. Most participants would obtain their insurance through regional or corporate alliances for purchasing health care, although care provided by the Department of Defense, the Department of Veterans Affairs, and the Indian Health Service would remain an option for some people and Medicare would continue. The alliances would offer participants a choice of insurance plans, all of which would cover the same services. Supplementary insurance would be available for services not covered in the standard package and for certain cost-sharing amounts. The costs of the plans would be financed by premiums paid by employers and households, subsidies provided by the federal and state governments, and payments from programs such as Medicaid. The new system would be fully operational nationwide by 1998, but states would have the opportunity to participate as early as 1996.

Another major objective of the proposal is to restrain the growth of health care expenditures. To accomplish this goal, the proposal includes many structural and institutional changes that would encourage competition in the health sector. In addition, it would impose limits on the growth of premiums for the standard package of benefits and modify somewhat the tax treatment of employment-based health benefits.

As part of implementing and financing the new system, the Administration's proposal would also completely restructure the Medicaid program, significantly modify the Medicare program, and fundamentally change many components of both the private and the public systems for financing and delivering health care. But because of its scope and complexity, a detailed description of all elements of the proposal is not feasible in this report. This chapter, therefore, is limited to a summary of the features of the proposal that bear on the new program's likely costs, its appropriate budgetary treatment, and its possible impacts on the economy. It discusses how the proposal would achieve universal insurance coverage, modify existing programs and initiate others, finance the new system, divide responsibilities among governments and the institutions that would be established, and control the costs of health care.

The Provision of Health Insurance

The core of the Administration's proposal deals with defining the insurance coverage it would provide and with establishing the institutions that would be needed to operate the new system.

Establishing a Universal Entitlement

The proposal would guarantee that citizens and certain other people residing in the United States would have health insurance coverage for a standard package of benefits. Access to services in the standard package could not be denied an eligible individual even if the required premium payments were not made, the provider of the insurance coverage went bankrupt, or the institutions responsible for administering the new system failed to fulfill their

obligations. That package would cover the following:

- Hospital services;
- Services of health professionals;
- Emergency and ambulatory medical and surgical services;
- Clinical preventive services;
- Mental illness and substance abuse services;
- Family planning services and services for pregnant women;
- Hospice care;
- Home health care;
- Extended care;
- Ambulance services;
- Outpatient laboratory, radiology, and diagnostic services;
- Outpatient prescription drugs and biological products;
- Outpatient rehabilitation services;
- Durable medical equipment and prosthetic and orthotic devices;
- Vision care;
- Dental care;
- Health education classes; and
- Certain treatments under clinical investigation in approved research trials.

Coverage of some services would be phased in over time. Dental benefits, for example, would be very limited before 2001, and the coverage of mental illness and substance abuse services would also become more extensive in that year.

Although the proposed coverage of most services is comparable with that provided by relatively generous employment-based policies today, there are some differences. The coverage of preventive health services, for example, would be more extensive from the beginning than in most current health plans, as would the mental health and substance abuse benefits when they were fully phased in. By contrast, the prescription drug and hospital benefits in plans with higher cost sharing and (before 2001) the dental health benefits would be less generous than those that many employers currently provide.

Health Alliances

The Administration's proposal would expand the central role employers now play in purchasing health insurance and restructure the market for that insurance. All employers would have to pay part of the premiums for their employees' insurance. Moreover, the demand side of the health insurance market would be reorganized in order to engender greater market power for individuals and small firms, enable people to have a choice of health plans at a reasonable cost, and provide incentives for health plans to compete on the bases of both cost and quality.

To accomplish these goals, the proposal would establish a nationwide system of regional purchasing alliances. Most people who worked for firms with 5,000 or fewer full-time employees, as well as most people who were not in the labor force (including Medicaid beneficiaries), would be required to obtain health insurance coverage through those alliances. Medicare beneficiaries, however, would generally continue their coverage through that program.

Firms with more than 5,000 full-time employees, firms participating in large multiemployer group plans, rural electric cooperatives and telephone cooperative associations, and the U.S. Postal Service would be entitled to establish separate corporate purchasing alliances. Full-time employees of firms that did so would have to purchase their coverage through their firm's corporate alliance unless they had a spouse who worked for an employer that participated in a regional alliance. Such two-worker families could choose to obtain their insurance through either the corporate or the regional alliance.

Federal civilian employees would obtain their coverage through regional alliances starting in 1998, and the Office of Personnel Management (OPM) would make available to them one or more supplementary plans. OPM would also develop one or more plans that would supplement Medicare's benefits for retired federal workers and their dependents.

People who are now eligible for health coverage through certain federal agencies would still be able to receive their standard benefits through those agencies. Active-duty members of the armed forces would continue to receive their health benefits from the Department of Defense (DoD). Their dependents and military retirees could also obtain coverage through the DoD system if its resources permitted. Indians could obtain coverage through the Indian Health Service and veterans through the Department of Veterans Affairs system. Box 1-1 describes these aspects of the proposal.

Regional Alliances. These entities would be established by the states as either nonprofit organizations or state agencies. They would have nonoverlapping jurisdictions that could be a portion of a state or an entire state but could not cross state boundaries or

Box 1-1.
Health Plans Offered Through the Department of Defense, the Department of Veterans Affairs, and the Indian Health Service

In general, individuals who are currently eligible for health services from government agencies could receive their standard benefits through health plans offered by those agencies. Unlike the current situation, however, people selecting a government plan could not simultaneously participate in another plan covering the standard benefit package.

The Secretary of Defense would establish one or more Uniformed Services Health Plans that would cover at least all the items and services in the standard benefit package. Active-duty personnel would be required to enroll in those plans, for which they would pay minimal amounts. Other people eligible for military health care would have the choice of enrolling in a military plan if one was available, a plan offered by a regional or corporate alliance (for those under age 65), or Medicare (for those age 65 and over). Premium payments and other cost-sharing requirements for people who elected to enroll in military plans could not exceed the family share of premiums and cost-sharing amounts in health plans offered through regional alliances.

Military health plans would receive premium payments from Medicare on behalf of people enrolled in the Supplementary Medical Insurance program who selected a military plan. Conversely, the Department of Defense might make premium payments on behalf of people who were eligible for military plans but elected to participate in other plans.

In a similar manner, veterans could elect to enroll in health plans established by the Department of Veterans Affairs (VA). Those plans would be required to offer all the items and services in the standard benefit package, and they would also provide certain additional services specifically related to service-connected conditions. These additional services would be available to all veterans now eligible for them, regardless of whether they enrolled in a VA plan.

Low-income veterans and veterans with service-connected disabilities who enrolled in VA plans would not have to pay premiums or cost-sharing amounts, but most other veterans would pay amounts based on rules established by the regional alliance in the area in which the VA plan operated. VA health plans would be authorized, but not required, to enroll family members of VA enrollees subject to their paying the required premiums and cost-sharing amounts. Veterans who chose to enroll in other health plans would have no premiums paid on their behalf by the VA. VA plans would be eligible for reimbursement from Medicare, but only on behalf of participants who were eligible for Medicare, who also had no service-connected disabilities, and who were not defined by the VA as having low income.

The Indian Health Service (IHS) would also sponsor plans covering the standard benefit package for eligible Indians, who would not have to pay premiums or cost-sharing amounts. Family members who were not otherwise eligible could enroll in IHS plans but would be required to pay premiums and cost-sharing amounts. The IHS would make no payments for premiums or cost-sharing amounts for Indians who chose to enroll in non-IHS plans.

subdivide a metropolitan area within a state. Each regional alliance is supposed to ensure that its residents would have a choice of the health plans that contracted with the alliance, at least one of which would be a fee-for-service plan. The alliance would also be responsible for ensuring that residents had the necessary information with which to make informed choices and that they enrolled in a health plan.

In general, alliances would be required to contract with all health plans that met the state's standards and wished to offer insurance coverage in their area. Regional alliances could, however, refuse to contract with plans whose proposed premiums exceeded 120 percent of the target for the alliance's per capita premium or that had violated previous contracts with the alliance. The alliances would also collect funds from employers, households, and governments and make payments to the plans chosen by participants. Finally, they would have to meet federal requirements to keep their average premiums at or below specified targets.

Corporate Alliances. Corporate alliances would also have to offer participants a choice of plans, although that choice could be more restricted than in regional alliances. Specifically, corporate alliances would have to offer at least one traditional fee-for-service plan and at least two others of a different type, such as health maintenance organizations (HMOs). Like regional alliances, their responsibilities would include collecting and disseminating information about health plans and their outcomes, as well as meeting federally determined targets for cost containment.

Medicare and the Alliance System. The Medicare program would generally continue to function outside the system of regional and corporate alliances. Enrollment in plans offered through the alliances would be mandatory, however, for people eligible for Medicare if they or their spouse were employed at least 40 hours a month. In addition, some people could elect to stay in certain eligible plans when they became entitled to receive Medicare benefits. Finally, provided that they met certain requirements, states would also have the option to integrate all their Medicare beneficiaries into regional alliances.

Medicaid and the Alliance System. Medicaid beneficiaries who receive cash welfare payments would continue to be covered by Medicaid but would receive services in the standard benefit package through health plans offered by the regional alliances. These beneficiaries could choose any health plan that charged an average or below-average premium, would be absolved of other payments for premiums, and would have special limits on their cost-sharing liabilities. (They could choose a more expensive plan by paying the difference in premiums themselves.) For this group, the federal and state governments would also continue to make payments for benefits that Medicaid now covers but that would not be included in the standard benefit package.

In general, Medicaid beneficiaries who do not receive cash payments would no longer obtain coverage from Medicaid, except for long-term care and cost sharing required by Medicare. Instead, they would benefit both from the same subsidies available to other low-income people obtaining coverage through the alliance and from payments made by their employers if they were working. Almost all children eligible for Medicaid under current law would, however, continue to be covered for those services provided by Medicaid that would not be in the standard benefit package.

The Single-Payer Option for States. The Administration's proposal would allow states to opt out of the regional alliance system and establish a "single-payer" system of health care financing in which the state would pay all health care providers directly. States electing that option would assume responsibility for all people who would otherwise have been in regional alliances. They could also choose to enroll in their single-payer system all Medicare beneficiaries and people who would otherwise have been in corporate alliances.

Health Plans

The proposal envisions that people who obtained their health insurance through alliances would select from a variety of plans that contracted with their alliance, including fee-for-service plans, HMOs, and

point-of-service plans. Some people, however, might not be able to enroll in the plan of their choice--for example, if it was operating at capacity. Plans would have to comply with one of the three cost-sharing schedules that are specified in detail in the proposal--lower, higher, or combination cost sharing--as well as other requirements.

Requirements for Cost Sharing. Higher-cost-sharing plans would impose both specified deductible amounts and coinsurance (calculated as percentages of the providers' fees) according to a national schedule that is specified in the proposal. The use of flat copayments would be prohibited in those plans. Lower-cost-sharing plans would have no deductible amounts and no coinsurance (except for services obtained from providers outside the plan's network of providers). Such plans would charge flat copayment amounts for particular services according to a fixed national schedule also included in the proposal. Cost sharing in combination plans would basically follow the lower-cost-sharing model for in-network services and the higher-cost-sharing model for out-of-network services. In all three types of plans, maximum annual out-of-pocket payments would be the same: $1,500 for an individual and $3,000 for a family.

Requirements for Supplementary Coverage. The proposal would place strict requirements on supplementary health insurance. Insurers could not offer supplementary policies that would duplicate coverage offered in the standard benefit package. Any policies to cover services not included in the standard package would have to be available to all applicants, regardless of their state of residence, subject to capacity and financial constraints.[1]

All plans available through regional alliances would have to offer their enrollees supplementary coverage for cost-sharing amounts.[2] Lower- and combination-cost-sharing plans, however, would offer supplementary coverage only for deductible amounts and coinsurance required for services received from providers who did not have contracts with the plan. Only enrollees in a plan could purchase the supplementary coverage associated with that plan. Premiums for such coverage would have to be the same for all enrollees in a plan, and they would have to reflect the expected increase in use of services that would result from the reduced cost sharing. (Coverage of flat copayments, as opposed to coinsurance, would not be permitted.)

Certification Requirements for Health Plans. In order to contract with a regional alliance, health plans would have to be certified by the state in which the alliance was located. The criteria for certification would encompass standards for quality, financial stability, and capacity to deliver the standard benefit package, as well as requirements relating to community rating, enrollment, and coverage. Those for community rating would prohibit plans from varying premiums among residents of the alliance area (except for variations attributable to different types of families--individuals, couples, single-parent families, and two-parent families). The other requirements would prohibit medical underwriting and limitations on coverage so that no one would have coverage denied or restricted because of a preexisting condition. Those requirements would be stringent; a plan could not terminate or restrict coverage for any reason, even if enrollees did not pay their premiums.[3]

Corporate alliances could either contract with state-certified plans or offer self-insured plans that met the requirements of Title I of the Employee Retirement Income Security Act of 1974. Those plans would have to meet requirements for community rating, enrollment, and coverage just as plans offered by regional alliances would.

Requirements Relating to Essential Community Providers. All health plans would initially be required to enter into agreements to pay essential

1. Membership organizations and employers offering such policies could restrict them to their members and their own employees, respectively.

2. The proposal appears to prohibit corporate alliances from offering supplementary cost-sharing policies, but officials of the Administration have stated that they intended to place no constraints on corporate alliances. In fact, the proposal permits firms that formed corporate alliances to reimburse employees for those expenses.

3. Plans could, however, obtain approval to limit enrollment if they were operating at capacity or in order to maintain their financial stability.

community providers who wished to have such agreements. Essential community providers could either participate in the plan or receive payments from the plan without having a participating provider agreement. Certification as an essential community provider would be automatic for a wide range of private nonprofit and public providers that receive funding under the Public Health Service or Social Security Act.[4] Certified providers would also include Indian health programs and providers of school health services that would receive funding under the proposal, as well as other providers and organizations certified by the Secretary of Health and Human Services (HHS).

The requirement for health plans to contract with essential community providers would end five years after an alliance first offered a health plan. No later than March 2001, however, the Secretary of HHS would recommend to the Congress whether to continue, modify, or terminate the requirement.

Requirements Relating to Workers' Compensation and Automobile Insurance. All health plans that provided services to enrollees through participating providers would be required to provide or arrange for workers' compensation services for their enrollees. Workers' compensation carriers would reimburse health plans for those services. Workers' compensation services could, however, be provided through alternative means if the carrier and the injured worker agreed.

Similarly, enrollees would generally receive from their health plans any medical benefits to which they were entitled through their automobile insurance. Health plans would be required to arrange for referral services, as necessary, to ensure the appropriate treatment for injured individuals. Automobile insurance carriers would reimburse health plans for those services. As with workers' compensation insurance, injured individuals and carriers could agree to alternative arrangements.

4. Those providers would include community and migrant health centers, providers of health services for the homeless and people in public housing, family planning clinics, providers who treat people with AIDS (acquired immune deficiency syndrome) and are funded under the Ryan White Act, maternal and child health providers, and federally qualified health centers and rural health clinics.

Federal Program Initiatives and Expansions

In addition to the new program to provide universal health insurance coverage, the Administration's proposal would create several federal programs and would expand others. Changes in tax policy (discussed in a later section) would also benefit some people, such as those with large expenses for long-term care.

Medicare's Coverage of Prescription Drugs

Starting in January 1996, Medicare's Supplementary Medical Insurance (SMI) benefit package would cover prescription drugs for outpatients. This new benefit would have a $250 deductible amount, 20 percent coinsurance, and an out-of-pocket limit of $1,000. The deductible and out-of-pocket limit would be adjusted each year to ensure that neither the percentage of individuals satisfying the deductible nor the average percentage of enrollees receiving benefits would change.

Several new program requirements would attempt to restrain potential expenditures for prescription drugs. Medicare would limit reimbursement to pharmacists, generally paying them the lesser of the 90th percentile of pharmacies' charges for a particular drug or their acquisition cost plus a dispensing fee. In addition, drug manufacturers would have to provide rebates to Medicare for all nongeneric drugs sold to enrollees.

Home- and Community-Based Services for Severely Disabled People

The Administration's proposal would establish a new grant program for the states to provide home- and community-based services for people with severe disabilities. Although all people who met the disability criteria would be eligible to receive services from this program, it would not be an entitlement for disabled individuals; the number actually receiving services would depend on the amount of

funding appropriated. Federal contributions to the program, which would be phased in over seven years, would be capped, and states would be required to provide some funding.

The total federal budget for the program would be $4.5 billion in fiscal year 1996, rising to $38.3 billion in 2003. Increases in subsequent years would reflect changes in the consumer price index (CPI) and the size of the disabled population. As in Medicaid, a state's share of the funding would vary according to its per capita income, but the share would be much lower than in the Medicaid program, ranging from 5 percent to 22 percent of expenditures for services. If states transferred severely disabled people from the Medicaid program to the new program, thereby reducing federal expenditures for home- and community-based services under Medicaid, the federal budget caps for the new program would increase accordingly.

States would have to impose cost-sharing requirements on all program participants on a sliding scale according to income. Participants with family income below 150 percent of the poverty level would pay nothing; those with family income at or above 250 percent of the poverty level would pay the maximum cost-sharing rate of 25 percent.

Expansions in Medicaid's Coverage of Long-Term Care

Three features of Medicaid's coverage of long-term care would change under the Administration's proposal, two of which would expand eligibility for nursing home services. At their option, states could raise the amount of assets that may be excluded when determining the eligibility of single individuals for nursing home services (the asset disregard) from the current limit of $2,000 to as high as $12,000. In addition, all states would be required to grant eligibility for nursing home services to people who would meet the income and asset requirements for eligibility if their nursing home expenses were deducted from their income. (States currently have the option to grant eligibility to this group of people, but about one-third of the states do not do so.)

A third provision would require all states to allow nursing home residents who are Medicaid beneficiaries to keep at least $50 a month for their personal needs. Because almost half the states now set this allowance at the minimum allowed ($30), some beneficiaries would contribute less to the cost of their care. The federal government would pay for the resulting increase in Medicaid spending.

"Wraparound" Benefits for Low-Income Children

Because the current Medicaid program provides a wider range of services than those included in the standard benefit package, so-called wraparound benefits (apart from long-term care) would be provided to children now eligible for Medicaid. Although these benefits would be financed entirely by the federal government, states' maintenance-of-effort payments would, in effect, pay for roughly their traditional share of costs for these additional services for children in families receiving cash welfare benefits. Thus, the federal government would, in effect, take over the financing of these additional services only for children in families who did not receive cash benefits.

Expenditures for these benefits would be limited, however, based on the combined fiscal year 1993 federal and state spending for them. This limit would be updated to account for changes in the number of eligible children and adjusted by Medicaid-specific inflation factors through 1998 and by the "general health care inflation factor" combined with the rate of growth in the population under age 65 thereafter.[5]

5. For the 1996-2000 period, the "general health care inflation factor" would be the increase in the CPI plus specific amounts--1.5 percentage points in 1996, 1 percentage point in 1997, 0.5 percentage point in 1998, and zero in 1999 and 2000. After 2000, if the Congress did not act, the default factor would be the percentage increase in the CPI combined with the percentage growth in real gross domestic product per capita. (An actuarial adjustment would also be made in 2001.)

Funding for Graduate Medical Education and Payments to Academic Health Centers

The Administration's proposal would restructure the current system of federal subsidies for graduate medical education and academic health centers (and teaching hospitals) to account for the special costs they incur. It would emphasize the training of primary care physicians; both the alliances and Medicare would help to pay for the training of physicians. The proposal would also authorize $200 million a year for graduate nursing education and $400 million a year for Public Health Service programs for the training of minorities and of health professionals specializing in primary care.

A new National Council on Graduate Medical Education would authorize the number of residency positions, by specialty, in graduate medical education programs that received federal funding. At least 55 percent of residents who completed eligible residency programs would have to be in primary care--that is, in family medicine, general internal medicine, general pediatrics, or obstetrics and gynecology. That requirement would first hold for residents entering training in the 1998-1999 academic year.

Funding for the direct costs of approved training programs for physicians would be $3.2 billion in calendar year 1996, rising to $5.8 billion in both 1999 and 2000. In subsequent years, the amount would be the previous year's level increased by the general health care inflation factor. Under the Administration's proposal, Medicare would contribute $1.5 billion in fiscal year 1996, $1.6 billion in 1997 and 1998, and the 1998 level increased by the CPI in subsequent years. Thus, Medicare's relative contribution would probably decline after 2000 since total payments would almost certainly be rising faster than Medicare's contribution.

Medicare's relative contribution to payments to academic health centers (and teaching hospitals) for the indirect costs of graduate medical education would also probably decline over time. Such payments would total $3.1 billion in calendar year 1996, rise to $3.8 billion in 2000, and then increase in subsequent years by the general health care inflation factor. Of these amounts, Medicare would pay $2.1 billion in fiscal year 1996, $2.0 billion in 1997 and 1998, and that amount inflated by the CPI in subsequent years. The remaining funding for both the direct and indirect costs of graduate medical education would come as needed from a 1.5 percent assessment on total premiums paid to regional and multiemployer corporate alliances and from part of the 1 percent tax on the total payrolls of all other employers who established corporate alliances.

Expansion of the WIC Program

The proposal would establish a special Treasury fund subject to discretionary appropriations that, in addition to the regular appropriations for the Special Supplemental Food Program for Women, Infants, and Children (WIC), would help bring the program up to full funding by the end of fiscal year 1996 and then maintain full funding levels. To that end, the Secretary of the Treasury would credit annual amounts to the fund totaling $1.85 billion over the 1996-2000 period. These annual amounts would be available for spending, however, only if the regular appropriation for the year provided new budgetary authority for WIC at levels specified in the proposal.

Public Health Service Initiatives

Activities of the Public Health Service would expand significantly in a number of areas ranging from biomedical and behavioral research to health services for medically underserved populations. To accomplish that expansion, funding for a Public Health Service Initiative would be authorized.

Financing Provisions

Premiums paid by employers and households and payments by the federal and state governments would finance the insurance coverage obtained through the alliances. Employers would pay premi-

ums for all employees who worked at least 40 hours a month.[6] Except for Medicaid beneficiaries who receive cash assistance, nonelderly individuals and families would, in general, be responsible for paying the part of the premium that was not contributed by employers. Families with no workers, or with self-employed workers only, would be responsible for the entire premium for the plans they selected.

Government subsidies would be available, however, for low-income people and for people between the ages of 55 and 64 who had retired from the labor force. Employers, except for those that formed corporate alliances, would be entitled to subsidies that ensured that their payments for health insurance premiums did not exceed certain fractions of their payroll.

The costs of financing the subsidies, expanding the Medicare program, and augmenting various mandatory and discretionary federal health programs would be covered by states' maintenance-of-effort payments, higher SMI premiums, an increase in the excise tax on tobacco, an assessment on the payroll of firms that established corporate alliances, and other assessments and tax changes, as well as by various reductions in the Medicare and Medicaid programs.

Premiums Paid to Alliances

The premiums charged by any health plan offered through a regional alliance for the standard benefit package could vary only by the type of family (individual, couple, one-parent family, and two-parent family); they could not vary by age, sex, or health status. Premiums for plans offered by a corporate alliance, however, could also vary by geographic area. Moreover, the relationship among premiums for different types of families would be fixed and uniform across all regional alliances. For example, the premium for a couple would have to be twice that for an individual in the same plan.[7]

The distribution of premium payments among families and employers would be based on the premise that employers should pay about 80 percent of the premium for full-time workers, and families the remaining 20 percent. The actual proportions would vary, however, for several reasons.

Every family who enrolled in a plan offered by a regional alliance would be assigned an "alliance credit amount" that would equal 80 percent of the weighted average premium in the alliance for that type of family. The weighted average premium for a specific family type would be calculated by averaging premiums for that family type for all the plans in the alliance, weighting the premiums by the number of families of that type in each plan. The family's portion of the premium would be the difference between the premium for the plan selected by the family and the alliance credit amount, subject to various other adjustments, including subsidies.

In contrast, an employer's payment would not equal the alliance credit amount because families contain, on average, more than one worker for whom some employer would be paying premiums. An employer's payments would also not be determined by the premiums of the particular plans selected by its employees. Rather, for full-time workers in a specific family type, each employer's payments would take into account the number of workers of that family type in the alliance--for example, the more two-parent families there were with two full-time workers, the smaller the proportion of the 80 percent employer share any particular employer would have to pay.[8]

More specifically, setting aside the possibility of other adjustments (such as the subsidies for firms that are described below), an employer's payments would be calculated as follows:

6. Two exceptions are children under age 18 and full-time students under age 24 who are dependent on their parents; they would be covered by their parents' policies even if they were employed.

7. Each corporate alliance would have some discretion, but all plans it offered within the same geographic area would have to have the same relationship among premiums for different types of families.

8. In calculating these payments, families with members eligible for Aid to Families with Dependent Children, Supplemental Security Income, or Medicare would be excluded. In addition, an employer's payments would be scaled proportionately for part-time workers, defined to be those who work between 10 and 30 hours per week.

- For individuals, the amount paid by each employer would be 80 percent of the weighted average premium for single individuals in the alliance.

- For couples, the amount would be 80 percent of the total premium payments for couples (that is, the number of couples in the alliance multiplied by the alliance's weighted average premium for couples) divided by the number of couples plus the number of "extra workers." Extra workers are the full-time-equivalent workers in couples with more than one working member. This complicated formulation means that the amount an employer would pay per worker would be reduced as the number of workers in the alliance who were part of a couple rose relative to the number of couples. The reductions in an employer's payments from this adjustment, which derives primarily from the presence of two-worker couples, would be spread among couples without a worker or with only one part-time or full-time worker.

- For both single- and two-parent families, an employer's payments would equal 80 percent of the combined total premium payments for both family types divided by the sum of the number of single-parent families, the number of two-parent families, and the number of extra workers in two-parent families. The aggregation of single- and two-parent families would ensure that an employer paid the same amount for employees in families with children, regardless of the number of parents in the family.

Unlike employers in regional alliances, those that formed corporate alliances would pay an amount similar to the alliance credit amount--namely, 80 percent of the weighted average premium in the corporate alliance for employees in each type of family. (Because the corporate alliance would receive payments for spouses eligible to enroll in other alliances, however, the cost per worker would be reduced in much the same way as for an employer in a regional alliance.) An exception would apply to full-time workers with average annual earnings of less than $15,000 (indexed by the CPI after 1994). For these workers, the employer would have to pay the greater of 80 percent of the weighted average premium or 95 percent of the premium of the lowest-cost plan offered by the corporate alliance that had either lower or combination cost sharing.

Employers in either regional or corporate alliances could pay more than the required minimum amounts on behalf of their employees, but their additional payments for the standard benefit package could not exceed the amount of the family share for the highest-cost plan in the alliance. If an employer chose to pay more, the amounts its employees owed would be reduced correspondingly. Such voluntary payments would have to be equal for all employees in the same type of family, however, regardless of the plans that were selected. Moreover, if the employer's payments totaled more than the premium of the plan selected by the employee, the difference would be returned to the employee (and included in taxable income).

Individuals and families would be responsible for the family share of the premium--that is, the difference between the premium charged by the plan they selected and the alliance credit amount--unless their employers paid more than the required minimum. For most individuals and families, their obligation would average about 20 percent of the total premium costs, but it could be more or less depending on whether they selected a plan with an above- or below-average cost.

Individuals and families with no worker or only a part-time worker would be responsible for some or all of the employer portion, as well as the family portion, of their premiums.[9] The self-employed would pay 7.9 percent of their self-employment income or the employer portion, whichever was lower, even if their family had another full-time worker. (The required percentage would be lower if they were eligible for the subsidies provided to low-wage firms that are discussed below.)

If some employers and families did not pay the premiums they owed to regional alliances, other

9. A family would not be responsible for the employer share if one of its members was employed full time for that month or if two members worked part time and their combined hours of employment totaled at least 120 that month.

employers and families in those alliances would bear the consequences. Each year, an alliance would estimate the amount of premiums that it would be unlikely to collect, adjusted for over- or underestimates in the previous year. It would then adjust the premiums for each type of family by the same proportion in order to collect the desired total from those expected to pay the amounts they owed.

Subsidies

The obligation to pay premiums that the Administration's proposal would place on employers and families would be reduced by a variety of subsidies designed to assist low-income families and employers. These subsidies would be available only for families that obtained, and employers that paid for, coverage through regional alliances. In other words, employers that established corporate alliances would not be eligible for subsidies and would have to keep the amounts paid by their low-income employees below certain limits.

Subsidies for Families. Families receiving benefits from Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) and people whose income was below a very low threshold ($1,000 in 1994, inflated by the CPI thereafter) would not have to pay the family portion of the premium for plans with premiums at or below the weighted average for that type of family. The family's maximum obligation would rise with income so that at 150 percent of the poverty level a family would pay the lesser of 20 percent of the weighted average premium or 3.9 percent of income. Payments for the family portion would be limited to 3.9 percent of income for all families with income below $40,000 (in 1994, inflated by the CPI thereafter). If no plan with a premium at or below the weighted average was available (for example, because all such plans were at capacity), the family's obligation would stay the same and the amount of the government subsidy would increase.

Subsidies would also be available for individuals and families who were responsible for paying part or all of the employer share of their premiums and for the self-employed who worked part-time and whose remaining obligation for the employer share was not met by the work of other family members. The subsidies would be set on a sliding scale and would be phased out when nonwage income--which includes items such as rents, interest, and dividends--reached 250 percent of the poverty level.

Families in regional alliance plans who had income below 150 percent of the poverty level would also be eligible for reductions in cost sharing if they lived in areas in which no lower- or combination-cost-sharing plan was available at a cost that did not exceed the weighted average premium for their type of family. Families meeting those criteria would be obligated only for the cost-sharing amounts they would have paid if they were enrolled in lower-cost-sharing plans. Regional alliances would pay the remainder to the plans. Special subsidies for cost sharing would also apply to Medicaid beneficiaries, who would pay only 20 percent of the copayment amounts required by lower- or combination-cost-sharing plans. The plans themselves would generally finance the cost-sharing subsidies for Medicaid beneficiaries.

Early retirees who would be eligible for Medicare's Hospital Insurance (HI) benefits when they turned 65 would receive special subsidies for their premiums. (Early retirees would be people between the ages of 55 and 64 who were not employed full time.) Spouses under age 65 who were not employed and other dependents of early retirees would also be subsidized. Retirees in these families would be entitled to government subsidies covering the employer share, leaving them to pay only the difference between the premium for the plans they chose and the alliance credit amount. The subsidies would be reduced by employers' payments for retirees or their spouses who worked part time. If the spouse of a retiree worked full time, no government subsidy would be necessary.

Subsidies for Firms. The Administration's proposal would also place limits on the premiums paid by employers in regional alliances. With the exception of the federal, state, and local governments, which would not be entitled to caps on their premium payments for employees until 2002, an employer's premium payments to regional alliance

plans would generally not exceed 7.9 percent of payroll.[10]

Small, low-wage employers would have lower caps, which would vary according to both the size of the firm and its wage level. The lowest proportion of payroll (3.5 percent) would be paid by firms with fewer than 25 full-time-equivalent employees and average annual wages per full-time-equivalent employee of not more than $12,000. The employers' obligation would increase to reach 7.9 percent for firms with 75 or more employees or average wages of more than $24,000. The proportion of small employers that would be eligible for these additional subsidies would fall over time because the wage thresholds on which the subsidies are based would not be indexed.

Changes in the Internal Revenue Code

Receipts from a variety of sources would finance the Administration's proposal, although some new tax incentives would reduce revenues. Detailed information on the amendments to the Internal Revenue Code contained in the Administration's proposal is available in a recent publication from the Joint Committee on Taxation.[11] Therefore, only a summary of those provisions is provided here.

One provision would increase the excise tax on cigarettes by 75 cents per pack and the taxes on other tobacco products by approximately the same amount per pound of tobacco content. In addition, employers that no longer had to pay for their retirees' health coverage would have to pay a temporary assessment. Employers that established corporate alliances would be required to pay a 1 percent payroll tax, in part to help pay for the federal grants for graduate medical education, nursing education, and academic health centers. Multiemployer corporate alliances and regional alliances would have to pay a 1.5 percent assessment on premiums for the same purposes.

Other provisions would broaden the definition of the tax base for self-employed people. First, more business income of shareholders in S corporations would be treated as "wages" for the purpose of calculating the corporation's eligibility for subsidies of its premiums. Specifically, individuals who owned more than 2 percent of the stock in an S corporation and who participated materially in the business would have their distributive share of the corporation's income from the service-related business treated as wages for this purpose. Likewise, more business income of limited partners in partnerships would be treated as wages for the same purpose. The added income of S corporation shareholders and limited partners would also become subject to employment taxes. These changes would not only reduce subsidies for employers but would also increase payroll tax receipts (as well as future benefits from Social Security and unemployment insurance).

The proposal would also require all state and local employees to pay Medicare's HI payroll tax. Currently, workers hired before April 1, 1986, in states that do not have a voluntary participation agreement with the federal government do not pay this tax, although many are eligible for Medicare's benefits through their spouse or nongovernmental employment. The increase in Medicare's revenue from this proposal would be partially offset by higher future spending because more people would participate in the program.

Two other provisions would reduce subsidies received by high-income retirees. Medicare enrollees with modified adjusted gross income above a specified threshold amount ($90,000 for single taxpayers and $115,000 for married taxpayers filing a joint return) would, in effect, have to pay higher premiums for Supplementary Medical Insurance. The maximum SMI premium for high-income Medicare beneficiaries would cover about 75 percent of the average benefits per enrollee, up from the current level of about 25 percent. In addition, high-income early retirees who would otherwise be eligible to receive subsidies for the employer share of

10. Employers eligible to establish corporate alliances that chose to participate in a regional alliance would not be eligible for these subsidies for the first four years. The subsidies would, however, be phased in during the next four years.

11. Joint Committee on Taxation, *Description and Analysis of Title VII of H.R. 3600, S. 1757, and S. 1775 ("Health Security Act")*, JCS-20-93 (December 20, 1993).

their health insurance premiums would be required to pay that share themselves.

The Administration's proposal would leave the tax treatment of employers' payments for health benefits largely untouched until 2004. As under current law, the proposal would allow the exclusion from employees' incomes of employers' payments for the standard benefit package and for cost-sharing amounts under the standard package, including premiums for cost-sharing supplements. But the proposal would expand the exclusion for employers' payments for qualified long-term care insurance.

Beginning in 2004, employer-paid premiums for supplementary coverage of additional services would no longer be excludable from employees' income for income tax and payroll tax purposes. In keeping with that provision, beginning in 1997, coverage provided through flexible spending accounts would be tax-exempt only for benefits related to the standard package. Also beginning in that year, employers generally could not include health benefits in "cafeteria" plans.

If employers chose to pay more of their employees' premiums than the minimum required, they would have to make equal voluntary payments for all employees in the same type of family. Thus, the employer's total payment could exceed the total premium of the plan selected by an employee. In such a case, the employee would be entitled to a cash rebate that would be subject to both income and payroll taxes.

The proposal also would expand the income tax subsidy for health insurance purchased by the self-employed; it would do so by making permanent and later increasing a tax deduction for health insurance premiums. The proposal would reinstate the 25 percent deduction that expired at the end of 1993 and increase it to 100 percent of premiums for the standard benefit package beginning in 1997 (or 1996 if the state had begun participating in the new system).

By contrast, the proposal would put tighter limits on deductions for taxpayers who prepaid their health insurance premiums. If taxpayers made those premium payments or other payments for medical care, the benefits from which would extend for more than a year after the payment, that amount would be treated as having been paid on a pro rata basis over the period in which the benefits were received. That provision would preclude taxpayers from claiming a large tax deduction for a lump-sum payment for future health benefits.

Three tax provisions related to long-term care would lower revenue. One such provision would provide tax relief for individuals with high expenses for long-term care, and another would offer a tax subsidy to encourage people to purchase private insurance for long-term care. Taxpayers could claim an itemized deduction for spending on qualified long-term care services provided to themselves, their spouses, or dependents for which they had not been reimbursed, if those expenses plus their other qualified medical expenses exceeded 7.5 percent of their adjusted gross income. Premiums for qualified long-term care policies would also count as qualified medical expenses for purposes of itemized deductions. And as mentioned above, the exclusion of an employer's payment of premiums for qualified long-term care policies from an employee's income would be expanded; benefits received from such policies would also be excluded from income.

Other tax provisions in the Administration's proposal include changing the tax treatment of accelerated death benefits under life insurance contracts, providing tax incentives to encourage primary care physicians to practice in areas designated as having a shortage of health professionals, and giving tax credits for personal assistance services for disabled workers.

Reductions in the Medicare Program

A major part of the funding for the proposal would come from reductions in the Medicare program. Some of them would affect the Hospital Insurance program, some would affect the Supplementary Medical Insurance program, and some would affect both. (Increases in SMI premiums for high-income enrollees were discussed above because they would be collected through the income tax system.)